STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND DESIGNATION OF INDEPENDENT MEDICAL REVIEW AGENT

In accordance with California Insurance Code section 10169(e), an insured may designate an agent to act on his or her behalf to assist that insured with the Independent Medical Review (IMR) process. If you want to give another person the authority to assist you with your Independent Medical Review (IMR), complete Parts A and B below.

Unless you wish to designate another person to assist you with the IMR process, if you are a parent or legal guardian filing this IMR for a child under the age of 18, you do not need to complete this form, but you must complete the Application for Independent Medical Review (IMR).

If you are filing this IMR or complaint for a patient who cannot complete this form because the patient is either incompetent or incapacitated, and you have legal authority to act for this patient, please complete Part B only. Also, attach a copy of the power of attorney for the health care decisions or other documents that say you can make decisions for the patient.

PART A: Patient/Insured:
I allow the person named below in Part B to assist me in my IMR filed with the California Department of Insurance (CDI). I allow the CDI and IMR staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information. I understand that only information related to my IMR or complaint will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing. This authorization will expire one year from the date below, except as regarding the Department's internal use or as otherwise allowed by law.

Name of Patient (Print): _____

Signature of Patient or Insured: _____ Date: _____

PART B: Person Assisting Patient with IMR

Name of Person Assisting (print) _____

Signature of Person Assisting _____

Address_____

Relationship to Patient_____

Daytime Phone #_____

Evening Phone #_____

Email Address (if available): _____

____ My power of attorney for health care decisions or other legal documents is attached.

Return the completed form to Department of Insurance, Health Claims Bureau, IMR Unit, 300 S. Spring Street, 11th Floor, Los Angeles, CA 90013. If you have any questions, the Department can be reached at (800) 927-4357, Outside of California (213) 897-8921, fax # (213) 897-5891.